DOCUMENT RESUME

ED 431 977 CG 029 327

TITLE	School-Based Client Consultation, Referral, and Management of Care. A Technical Aid Packet.
INSTITUTION	California Univ., Los Angeles. Center for Mental Health in Schools.
SPONS AGENCY	Health Resources and Services Administration (DHHS/PHS), Washington, DC. Maternal and Child Health Bureau.
PUB DATE	1998-01-00
NOTE	93p.
AVAILABLE FROM	School Mental Health Project, Center for Mental Health in Schools, Dept. of Psychology, UCLA, 405 Hilgard Ave., Los Angeles, CA 90095-1563; Tel.: 310-825-3634; Fax: 310-206-8716; e-mail: smhp@ucla.edu; Web site: http://smhp.psych.ucla.edu (minimal fee to cover copying, postage and handling).
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Consultation Programs; Consumer Economics; Counseling; Evaluation; Intervention; *Mental Health; *Referral; *School Counseling
IDENTIFIERS	Case Management; Transition Management; Triage

ABSTRACT

This booklet assumes that the first question that a mental health professional asks should not be what's wrong with this person, but what's making this person function like this. The answer may be that something's wrong with the way the person's environment is functioning, and, therefore, it is the environment that really should be changed, if feasible. Of course, whether or not the problem resides with the environment, the person may require some special assistance. The focus of this technical aid packet is on making decisions about what assistance is needed, how serious the need is, where a student/family should go to get it, and how to ensure it is provided in coordinated and integrated ways. Section 1, "Student Clients as Consumers," explores a consumer-oriented approach, and introduces the remaining sections. Section 2, "Referral as Intervention," offers guidelines for teachers and staff regarding the prereferral and referral process, providing services, and following up on referrals, including consumer feedback. Section 3, "Managing 'Care,' Not Cases," explores initial monitoring of care, ongoing management of care, and systems of care. Appendixes provide materials to aid in the triage process, establishing a system to provide clients with ready access to information about referral resources, assisting clients with referrals, and assuring quality of care. (MKA)

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*From the Center's Clearinghouse ...**

A Technical Aid Packet on

School-Based Client Consultation, Referral, and Management of Care

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U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
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Support comes in part from the Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health.

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UCLA CENTER FOR MENTAL HEALTH IN SCHOOLS*

Under the auspices of the School Mental Health Project in the Department of Psychology at UCLA, our center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

MISSION: ***To improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools.***

Through collaboration, the center will

- **enhance practitioner roles, functions and competence**
- **interface with systemic reform movements to strengthen mental health in schools**
- **assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools**

Consultation Cadre ***Clearinghouse***

Newsletter ***National & Regional Meetings***

Electronic Networking

Guidebooks ***Policy Analyses***

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*In 1996, two national training and technical assistance centers focused on mental health in schools were established with partial support from the U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health. As indicated, one center is located at UCLA; the other is at the University of Maryland at Baltimore and can be contacted toll free at 1-(888) 706-0980.

(1/98)

What is the Center's Clearinghouse?

The scope of the Center's Clearinghouse reflects the School Mental Health Project's mission -- to enhance the ability of schools and their surrounding communities to address mental health and psychosocial barriers to student learning and promote healthy development. Those of you working so hard to address these concerns need ready access to resource materials. The Center's Clearinghouse is your link to specialized resources, materials, and information. The staff supplements, compiles, and disseminates resources on topics fundamental to our mission. As we identify what is available across the country, we are building systems to connect you with a wide variety of resources. Whether your focus is on an individual, a family, a classroom, a school, or a school system, we intend to be of service to you. Our evolving catalogue is available on request; eventually it will be accessible electronically over the Internet.

What kinds of resources, materials, and information are available?

We can provide or direct you to a variety of resources, materials, and information that we have categorized under three areas of concern:

- Specific psychosocial problems
- Programs and processes
- System and policy concerns

Among the various ways we package resources are our *Introductory Packets, Resource Aid Packets, special reports, guidebooks*, and *continuing education units.* These encompass overview discussions of major topics, descriptions of model programs, references to publications, access information to other relevant centers, organizations, advocacy groups, and Internet links, and specific tools that can guide and assist with training activity and student/family interventions (such as outlines, checklists, instruments, and other resources that can be copied and used as information handouts and aids for practice).

Accessing the Clearinghouse

- E-mail us at **smhp@ucla.edu**
- FAX us at (310) 206-8716
- Phone (310) 825-3634
- Write School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, Los Angeles, CA 90095-1563

Check out recent additions to the Clearinghouse on our Web site
http://smhp.psych.ucla.edu

All materials from the Center's Clearinghouse are available for a minimal fee to cover the cost of copying, handling, and postage. Eventually, we plan to have some of this material and other Clearinghouse documents available, at no-cost, on-line for those wi ' Internet access.

If you know of something we should have in the clearinghouse, let us know.

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It is easy to fall into the trap of thinking that interventions to address barriers to student learning and enhance healthy development should always be directed at the individual. This happens because problem definitions tend to be formulated in person-centered terms and because person-centered models of cause and correction dominate professional thinking. Consequently, most of what is written about such problems emphasizes person-focused intervention.

Focusing only on individuals tends to limit assumptions about what is wrong and what needs to change. Adopting a broader, transactional perspective of barriers to student learning suggests that intervention often should be directed at changing environments and programs as a necessary and sometimes sufficient step in working in the best interests of a youngster.

In the following work, we assume the first question that a professional asks should **not** be *What's wrong with this person?*

The first question should be

What's making this person function like this?

The answer may be that something's wrong with the way the person's environment is functioning, and therefore, it is the environment that really should be changed -- if feasible.

Of course, whether or not the problem resides with the environment, the person may require some special assistance.

The focus of this *technical aid packet* is on decisions about what assistance is needed, how serious the need is, where a student/family should go to get it, and how to ensure it is provided in coordinated and integrated ways.

School-Based Client Consultation, Referral, and Management of Care

Section I

Student Clients as Consumers

A Consumer-Oriented Approach

Referral: More than Giving a Name and Address

Managing *Care*, Not *Cases*

Section II

Referral as an Intervention

Referral: A Transition Intervention

The Prereferral Process: A Guide

The Referral Process: Some Guidelines and Steps

Providing Information About Services

Developing Ways to Facilitate Access to Service

- Highlighting the Most Accessible Referral Resources
- Referral Resource Files
- Support and Direction for Follow-through
- Personal Contact with Referral Resources
- Enhancing On-Campus Services

Follow-up on Referrals (including consumer feedback)

Section III

Managing *Care*, Not *Cases*

Initial Monitoring of Care

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Appendices

Examples of Resource Materials and Procedures

In this appendix, you will find materials to aid in (1) the triage process, (2) establishing a system to provide clients with ready access to information about referral resources, (3) assisting client referrals, and (4) assuring quality of care.

A. Tools to Facilitate *Triage*

1. Triage Review Request Form
2. Student's View of the Problem -- Initial Interview Forms

B. Tools to Enhance *Client Access to Information on Referral Resources*

1. Examples of Resource Information Handouts for Students/Families
2. Description of Referral Resource Files
3. Example of One District's Referral Policy

C. Tools to *Assist Clients with Referrals*

1. Referral Decisions -- Summary Form
2. Guidelines and Follow-up Forms to Aid Referral Follow-through

D. Tools to Aid in *Assuring Quality of Care*

1. Follow-up Rating Forms -- Service Status
2. Management of Care Review Form

Everyone would do well to gain a bit of consumer savvy before contacting a professional resource -- not because professionals are out to rip people off (although there are a few shady practitioners in any profession) but because the majority of professional services by their very nature have built-in biases and usually reflect prevailing treatment dogma.

Practitioners often promote only one view of a problem and the needed treatment, and may also use confusing jargon or perhaps overly complex or unproven theories and practices.

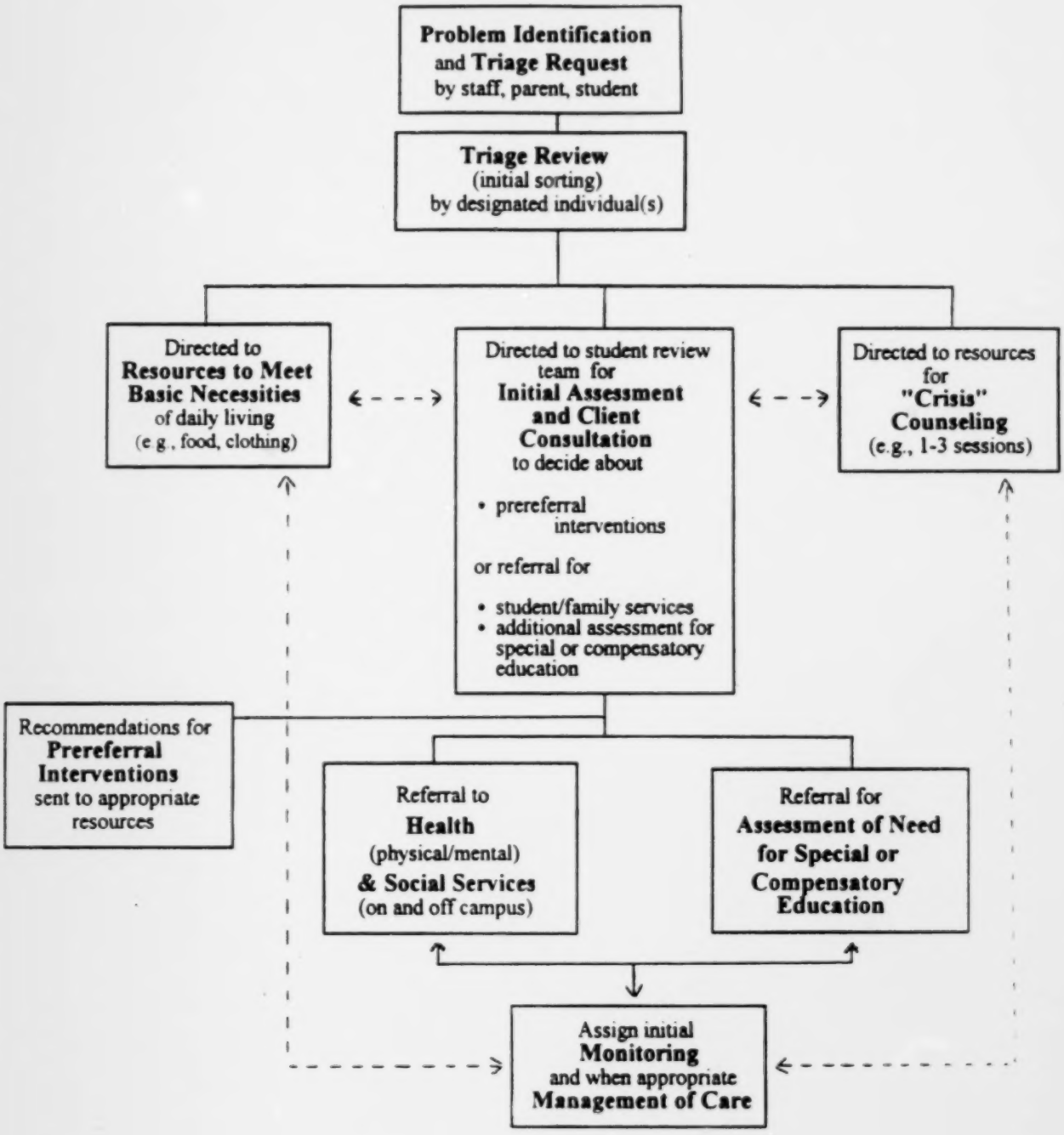
In looking for help the consumer's problem is twofold:

to identify feasible resources

and then

to evaluate their appropriateness.

Problem Identification, Triage, Assessment and Client Consultation, Referral, and Management of Care


Problem Identification and Triage Request by staff, parent, student
Triage Review (initial sorting) by designated individual(s)
Directed to Resources to Meet Basic Necessities of daily living (e g , food, clothing)
Directed to student review team for Initial Assessment and Client Consultation to decide about
• prereferral interventions
or referral for
• student/family services
• additional assessment for special or compensatory education
Directed to resources for "Crisis" Counseling (e.g., 1-3 sessions)
Recommendations for Prereferral Interventions sent to appropriate resources
Referral to Health (physical/mental) & Social Services (on and off campus)
Referral for Assessment of Need for Special or Compensatory Education
Assign initial Monitoring and when appropriate Management of Care

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Guidelines

Problem Identification, Triage, Assessment and Client Consultation, Referral, and Management of Care

Problem Identification and Triage Request

- Problems may be identified by anyone (staff, parent, student)
- There should be a Triage Request Form that anyone can access and fill out.
- There must be an easily acceptable place for people to turn in Triage Requests.
- Everyone should be informed of the process for making a Triage Request and what follows such a request.

Triage Review

- Several individuals should be designated and trained to review, sort, and direct forms every day to appropriate resources. These individuals can work independently of each other in sharing the task. For example, different individuals can do reviews on specified days or for an entire week.
- After the sorting is done, the reviewer should send a status information form to the person who identified the problem (assuming it was not a self-referral).

Students/Families Directed to Resources or for Assessment and Client Consultation

- For resources to meet the basic necessities of daily living (e.g., food, clothing), the triage reviewer should provide the student/family with information directly or through the person who identified the problem.
- If a problem clearly requires immediate counseling for a few sessions to help a student/family through a crisis, the triage reviewer should direct the form to the appropriate person designated to make assignments to available on-site crisis counselors.
- All other forms are directed to a small student review "team" (1-3 trained professionals) for further analysis and recommendations. (If there is a large number of requests for such reviews, several teams might be put into operation.) Members of such a team might not meet on all cases since some can be reviewed independently with recommendations made and passed on to subsequent reviewers for validation or revision. For complex problems, however, the team will have to meet and probably will need to gather more information from various involved parties (e.g., teacher, parent, student).
- All analyses and recommendations are shared with the student/family during a client consultation session at which decisions are made about appropriate course of action (e.g., referrals).

Prereferral Interventions, Referral for Assessment to Qualify for Special Services, or Referral to Health and Social Services

- In many instances, "prereferral interventions" should be tried. This requires that the school has or develops the type of resources that can be used to help classroom teachers learn and try new strategies. By monitoring the impact of such interventions, it can be decided whether they are sufficient for handling the problem. At the very least, they will provide additional data on what isn't working and what might.

- When students/families are referred for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Initial monitoring should be designed to determine follow-through and possible need for additional referrals.

- Referrals for assessment to determine need for special or compensatory education often are delayed because of a waiting list. Back logs must be monitored procedures used to reduce delays (e.g., by arranging for 1-2 days of intensive assessment and review).

Management of Care

- Some situations require only initial monitoring (e.g., to ensure follow-through). Persons must be identified and trained to function as such monitors and a system developed for assigning them as needed.

- Other situations require ongoing management of care to ensure
  (a) interventions are coordinated, integrated, and appropriate
  (b) problem analysis is ongoing
  (c) intervention impact is evaluated
  (d) interventions are revised as needed
  and so forth.

  There are many models for managing care. For example, one common approach is to assign the primary responsibility for managing care to the professional who has the greatest involvement (or best relationship) with the student/family. All potential managers of care need training for the role.

- One key and often neglected function of the person with primary responsibility for managing care is to provide appropriate status updates to *all* parties who should be kept informed (e.g., teachers, administrators).

Section I

Student Clients as Consumers

A Consumer-Oriented Approach

Referral: More than Giving a Name and Address

Managing *Care*, Not *Cases*

STUDENT CLIENTS AS CONSUMERS

In the helping professionals, there has long been concern about processes that inappropriately distance, depersonalize, and desensitize practitioners from those they serve. Professionals interested in the politics of institutionalized interventions (e.g., doctoring, counseling, educating) take the concern further and worry about power imbalances that disempower individuals and groups and increase dependency on professional interveners. The complexity of these matters becomes more so for those working with minors and in schools. Questions about *What is in a youngster's best interest?* and *Who should decide?* arise daily when a student is having difficulties.

> In school settings, adults make many decisions for students, often without the involvement of the youngster's primary caregivers. As professionals know all too well, decisions made related to triage, referral, and "case" management often have profound, life-shaping effects. The intent, of course, is to benefit those involved. But decisions to delay assistance may exacerbate problems; referrals to unproven interventions are risky; and even the best interventions have potential negative "side effects" that lead to additional problems.

From another perspective, it is evident that decisions made about -- rather than with -- individuals often don't work out.

> *Because of all this, a basic assumption underlying the following material is that students must be involved in decisions to assist them. Relatedly, except in rare instances, parents or guardians also must be involved.*

Obviously, there are significant exceptions to this principle. However, as a general guideline, the benefits of its application for most young people and for society are likely to far outweigh the costs involved.

> After adopting this principle, it is a short leap to adopting the stance that school-based assistance for students and families should be *consumer-oriented.*

A Consumer-Oriented Approach

In a real sense, school personnel and the families and students they serve are all consumers. This is especially true for all those concerned about addressing barriers to student learning. What are they consuming? Information about causes and correction of learning, behavioral, emotional, and health problems. And, they want and deserve the best information available -- *information that clarifies rather than mystifies, information that empowers rather than increases dependency.*

Appropriately cautious information can

- put matters into proper perspective
- clarify general options for dealing with the problem
- ensure good decisions and follow through.

Unfortunately, the hardest time for people to get information and sort things out for themselves seems to be when there is a pressing concern. At such times, they often need help from others. For many parents and youngsters, public schools and related public agencies provide the most natural and ongoing contact point for discussing a youngster's problems. Indeed, in the United States, federal guidelines stress the obligation of schools to identify certain problems, inform parents of their rights related to special programs, and ensure that proper assistance is provided. Among other practices, such mandates involve schools in a range of activity related to *triage, referral,* and *management of care.* Although not always discussed as such, they also involve schools in *client consultation* processes.

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Processes related to triage, referral, and managing care often are carried out at school sites in ways that are not very consumer-oriented.

For example, professional referrals still tend to follow the practice of *"Here are three names/places to contact."* There is little or no sound evaluative information about the services of those to whom referrals are made; in particular, systematically gathered consumer feedback is virtually nonexistent. It should be clear that the appropriateness of a referral depends less on the referrer's perspective and preferences than on the match between the recommended service and the practical and psychological requirements of the client (financial costs, geographical location, program characteristics). Thus, even if professionals could (and they can't) adequately and objectively evaluate and ensure the quality of services to which they refer, they would still be confronted with the complex problem of determining that the service-client match will be a good one.

As a general guideline, all services should be based on the view that the more they reflect consumer-oriented considerations, the greater the likelihood of appropriate decisions.

For practices to be consumer-oriented, it is essential to clarify consumer needs as a group and as individuals. This requires gathering information about the nature and scope of problems in the immediate locale and for each given individual who is assisted. Also needed is good information clarifying the range of relevant intervention options and basic information about each (cost, location, program rationale and features, and, where feasible, previous consumer evaluations). And, it involves consultation processes that effectively involve clients in decisions.

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The Best Consumer Protection Is a *Good* Professional

All professionals, of course, mean to do good. But what constitutes a "good" professional? For consumer advocates, a consumer orientation is at the heart of the matter. Indeed, such an orientation is found in a set of professional guidelines formulated by the American Psychological Association. These guidelines state that members of a good profession:

1. Guide their practices and policies by a sense of social responsibility;
2. Devote more of their energies to serving the public interest than to "guild" functions and to building ingroup strength;
3. Represent accurately to the public their demonstrable competence;
4. Develop and enforce a code of ethics primarily to protect the client and only secondarily to protect themselves;
5. Identify their unique pattern of competencies and focus their efforts to carrying out those functions for which they are best equipped;
6. Engage in cooperative relations with other professions having related or overlapping competencies and common purposes;
7. Seek an adaptive balance among efforts devoted to research, teaching, and application;
8. Maintain open channels of communication among "discoverers," teachers, and appliers of knowledge;
9. Avoid nonfunctional entrance requirements into the profession, such as those based on race, nationality, creed, or arbitrary personality considerations;
10. Insure that their training is meaningfully related to the subsequent functions of the members of the profession;
11. Guard against premature espousal of any technique or theory as a final solution to substantive problems;
12. Strive to make their services accessible to all persons seeking such services, regardless of social and financial considerations.

Referral: More than Giving a Name and Address

Referrals for service are commonplace at school sites.

And, for the most part,

referrals are relatively easy to make.

BUT,

because most students are reluctant to follow-through on a referral, the process needs to go beyond simply giving a student (or family) a name and address.

Schools must develop effective referral *intervention* strategies.

That is, it is essential to have referral procedures in place that

- provide ready reference to information about appropriate referrals,
- maximize follow-through by using a *client consultation process* that involves students and families in all decisions and helping them deal with potential barriers.

Referrals should be based on (1) sound *assessment* (information about the client's needs and resources available) and (2) consumer-oriented *client consultation*. Although most assessment and consultation can be seen as a form of problem solving, such problem solving may or may not be an activity professionals share with clients.

In developing a consumer-oriented system, the intent is twofold:

- to provide consumers with ready access to information on relevant services
- to minimize abuses often found in professional referral practices.

At the same time, the hope is that a positive side effect will be a higher degree of client self-reliance in problem solving, decision making, and consumer awareness.

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Referrals are easy to make . . .

An old fable tells of an arthritic Bulgarian peasant and her encounter with a doctor. After an extensive examination, he diagnoses her problems and writes a prescription for medication, details a special diet, and recommends that she have hydrotherapy. The doctor's professional manner and his expert diagnosis and prescription naturally filled the woman with awe, and as she leaves his office, she is overcome with admiration and says the Bulgarian equivalent of "Gee, you're wonderful doctor!"

A few years pass before the doctor runs into the woman again. As soon as she sees him, she rushes up and kisses his hand and thanks him again for his marvelous help. The doctor, of course, is gratified. Indeed, he is so pleased that he fails to notice that she is as crippled as before.

unfortunately, data suggest that follow-through rates for referrals made by staff at schools sites are under 50%.

The fact is that the woman never got the medication because she neither had the money nor access to an apothecary. Moreover, her village had no provision for hydrotherapy, and the prescribed diet included too many foods she either did not like or could not afford.

Nevertheless, despite her continuing pain, she remained full of awe for the wise doctor and praised him to everyone who would listen.

(Adapted from Berne, 1964)

To aid in reviewing client need and consideration of potential resources, information is presented in an organized and comprehensible manner. To facilitate decision making, guidance and support are provided in exploring the pros and cons of the most feasible alternatives. To encourage consumer self-protection, basic evaluative questions are outlined for consumers to ask of potential service providers before contracting for services.

> Toward meeting all these ends, the process must be one of shared or guided problem solving with the objective of helping consumers (usually students and parents together) arrive at their own decisions rather than passively adopting the professional's recommendations and referrals.

A consumer-oriented, guided problem-solving approach eliminates a number of problems encountered in prevailing approaches. The process avoids making "expert" and detailed prescriptions that go beyond the validity of assessment procedures; and it avoids referrals based on "old boy" networks by ensuring clients have direct access to a well-developed community resource referral file.

> As with all assessment involved in decision making, the *assessment* process has three major facets: (a) a rationale that determines what is assessed, (b) "measurement" or data gathering (in the form of analyses of records, observations, and personal perspectives, as well as tests when needed), and (c) judgments of the meaning of what has been "measured."

The *consultation* process also has three major facets: (a) a rationale that determines the focus of consultation activity, (b) exploration of relevant information (including "expert" information), and (c) decision making by the consumers.

An example of some specific steps used in an assessment and consultation process is provided on the next page.

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Some Specific Steps in an Assessment and Consultation Process

(1) Initial screening of student/family (initial contacts with the home may be via phone conversations)

(2) Filling out of questionnaires by each concerned party (parents and student) regarding his or her perception of the cause of identified problems and their correction

(3) Gathering records and reports from other professionals or agencies when consumers agree it might be useful

(4) Brief, highly circumscribed testing, if necessary and desired by consumers

(5) Initial review of assessment findings to determine if enough information is available to proceed with client consultation

(6) Holding group conference(s) with immediately concerned parties to

- analyze problems and in the process to review again whether other information is needed (and if so to arrange for gathering it)
- arrive at an agreement about how a problem will be understood for purposes of generating alternatives
- generate, evaluate, and make decisions about which alternatives to pursue
- formulate plans for pursuing alternatives (designating support strategies to ensure follow-through)

(7) Follow-up via telephone or conference to evaluate the success of each pursued alternative and determine satisfaction with the process

Problem analysis and decision making can be accomplished in a session. However, if additional assessment data are needed, one or two assessment sessions and a subsequent conference are required.

Because some people have come to overrely on experts, some clients may be a bit frustrated when they encounter an approach such as the one just described. They want professionals to give a battery of tests that will provide definitive answers, and they want decisions made for them. (They are convinced they cannot make good decisions for themselves.) These individuals often are a product of the negative side effects of professional practices that mystify consumers and make them feel totally dependent on professionals.

Managing *Care*, Not *Cases*

Common terminology designates those whom professionals work with as "cases." Thus, considerations about making certain that clients connect with referral resources often are discussed as "case monitoring" and efforts to coordinate and integrate interventions for a client are designated "case management."

At the same time, efforts to ensure there are comprehensive and integrated resources to assist clients often refer to the expansion of "systems of care."

Given that words profoundly shape the way people, think, feel, and act, some professionals are arguing for use of the term "care" in place of "case." Such a move is in keeping with the view that care is a core value of helping professionals. It also is consistent with the growing emphasis on ensuring that schools are "caring communities." For these reasons, it seems appropriate to replace the term case management with that of *management of care*.

The focus in Section II of this technical resource aid is on principles and procedures to guide establishment of a comprehensive referral intervention. The perspective taken in developing such an intervention is that it should be consumer oriented and user friendly.

Section II

Referral as an Intervention

Referral: A Transition Intervention

The Prereferral Process: A Guide

The Referral Process: Some Guidelines and Steps

Providing Information About Services

Developing Ways to Facilitate Access to Service

- Highlighting the Most Accessible Referral Resources
- Referral Resource Files
- Support and Direction for Follow-through
- Personal Contact with Referral Resources
- Enhancing On-Campus Services

Follow-up on Referrals (including consumer feedback)

REFERRAL AS AN INTERVENTION

It is important to remember that referral is an intervention. Because it involves decisions about how to move from what is currently happening to a better state of affairs, it can be viewed as transition intervention.

Referral: A Transition Intervention

The referral process begins when someone identifies a problem and asks for help. Sometimes assistance can be given at this point so that the student does not need referral to special services. This type of assistance is often called *prereferral intervention.* Actually, it is the first and sometimes a sufficient phase of the referral process. The assessment data generated during this process also is useful in making triage decisions.

On the following pages is a resource aid to guide school-based efforts to plan and implement a *prereferral process.*

A guide for teachers and other school staff regarding . . .

The Prereferral Process

When a student is seen as having problems, the following steps may be helpful.

Related guidelines and materials are attached.

Step 1: Based on your work with the student, *formulate a description* of the student's problem.

Step 2: Have *a discussion* to get the student's view. You may want to include the family.

Step 3: Try *new strategies* in the classroom based on your discussion.

Step 4: If the new strategies don't work, *talk to others* at school to learn about additional approaches they have found helpful.

Step 5: If necessary, use the *school's referral processes* to ask for additional support services.

Step 6: Work with referral resources to *coordinate your efforts* with theirs for classroom success.

Step 1: Based on your work with the student, *formulate a description* of the student's problem (use the checklist as an aid) and then request a Triage Review (see Appendix A).

A Checklist to Aid in Describing the Problem

Teacher's Name: _____ Rm. _____ Date_____

Extensive assessment is not necessary in initially identifying a student about whom you are concerned. If a student is having a significant learning problem or is misbehaving or seems extremely disturbed, begin by checking off those items below that are concerning you.

Student's name:_____ Birth date: _____ Grade: _____

Social Problems
( ) Aggressive
( ) Shy
( ) Overactive
( ) _____

Achievement problems
( ) Poor skills
( ) Low motivation
( ) _____

Overall academic performance
( ) Above grade level
( ) At grade level
( ) Slightly below grade level
( ) Well below grade level

Absent from school
( ) Less than once/month
( ) Once/month
( ) 2-3 times/month
( ) 4 or more times/month

Other specific concerns:

Comments: If you have information about what is causing the problem, briefly note the specifics here.

Step 2: Have a discussion to get the student's view. You may want to include the family. (See suggestions below).

Exploring the Problem with the Student and Family

As you know the causes of learning, behavior, and emotional problems are hard to analyze. What looks like a learning disability or an attentional problem may be an emotionally-based problem; behavior problems often arise in reaction to learning difficulties; what appears as a school problem may be the result of a problem at home.

> It is particularly hard to know the underlying cause of a problem when the student is unmotivated to learn and perform. It will become clearer as you find ways to enhance the student's motivation to perform in class and talk more openly with you.

The following guide is to help you get a more information about a student's problem.

Make personal contact with student (and those in the home). Try to improve your understanding of why the student is having problems and see if you can build a positive working relationship. Special attention should be paid to understanding and addressing factors that may affect the student's intrinsic motivation to learn and perform.

1. Starting out on a positive note: Ask about what the student likes at school and in the class (if anything).
2. Ask about outside interests and "hobbies."
3. Ask about what the student doesn't like at school and in the class.
4. Explore with the student what it is that makes the things disliked (e.g., Are the assignments seen as too hard? Is the student embarrassed because others will think s/he does not have the ability to do assignments? Do others pick on the student? Are the assignments not seen as interesting?)
5. Explore what other factors the student and those in the home think may be causing the problem?
6. Explore what the student and those in the home think can be done to make things better (including extra support from a volunteer, a peer, etc.).
7. Discuss some new things the student and those in the home would be *willing* to try to make things better.

See student interview form in Appendix A.

Step 3: Try new strategies in the classroom based on your discussion.

Some Things to Try

The following list is meant as a stimulus to suggest specific strategies to try before referring a student for special help.

1. Make changes to (a) improve the match between a student's program and his/her interests and capabilities and (b) try to find ways for the student to have a special, positive status in the program, at the school, in the community. Talk and work with other staff in developing ideas along these lines.

2. Add resources for extra support (aide, volunteers, peer tutors) to help student's efforts to learn and perform. This includes having others cover your duties long enough for you to interact and relate with student as an individual.

3. Discuss with student (and those in the home) why the problems are occurring

4. Special exploration with student to find ways to enhance positive motivation

5. Change regular program/materials/environment to provide a better match with student's interests and skills

6. Provide enrichment options in class and as feasible elsewhere

7. Use volunteers/aide/peers to enhance the student's social support network

8. Special discussion with those in the home to elicit enhanced home involvement in solving the problem

9. Hold another special discussion with the student at which other staff (e.g., counselor, principal) join in to explore reasons for the problem and find ways to enhance positive motivation

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Step 4: If the new strategies don't work, talk to others at school to learn about additional approaches they have found helpful.

- Reach out for support/mentoring/coaching
- Participate with others in clusters and teams
- Observe how others teach in ways that effectively address differences in student motivation and capability
- Request additional staff development on working with students who have learning, behavior, and emotional problems

With respect to staff development, there are a variety of topics that might be pursued. These include:

- addressing barriers to learning within the context of a caring, learning community
- ways to train aides, volunteers, and peers to help with targeted students
- specific strategies for mobilizing parent/home involvement in schooling
- using specialist staff for in-class and temporary out-of-class help
- addressing the many transition needs of students.

Step 5: If necessary, use the *school's referral processes* to ask for additional support services.

Step 6: Work with referral resources to *coordinate your efforts* with theirs for classroom success.

Teacher Assistance Teams

One prereferral method uses teacher assistance teams (TATs) which also go by such labels as staff support teams, intervention assistance teams, etc. Stokes (1982) defines a TAT as "a school based problem-solving group whose purpose is to provide a vehicle for discussion of issues related to specific needs of teachers or students and to offer consultation and follow-up assistance to staff..." TATs are typically comprised of regular classroom, teachers; however, in some settings, TATs also include representatives from multiple disciplines, such as psychology or special education. TATs focus on intervention planning, usually prior to referral and assessment, rather than on placement. The TAT and the referring teacher meet to discuss problems the student is having, think of possible solutions, and develop a plan of action to be implemented by the referring teacher. Assessment data are gathered by TATs for the purpose of planning and monitoring the effectiveness of interventions. Follow-up meetings are held to discuss the effectiveness of the proposed interventions, and to develop other strategies if necessary. Ultimately, the TAT decides whether the student should be referred to special education (Garcia & Ortiz, 1988).

References

Stokes, S. (1982) *School-based staff support teams: A blueprint for action.* Reston, VA: Council for Exceptional Children.

Garcia, S.B., & Ortiz, A.A. (1988). *Preventing inappropriate referrals of language minority students to special education. Occasional Papers in Bilingual Education. NCBE New Focus #5* Silver Spring, MD: National Clearinghouse for Bilingual Education (EDRS # ED309591).

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The Referral Process: Some Guidelines and Steps

Effective referral *intervention* strategies involve procedures that

- provide ready reference to information about appropriate referrals
- maximize follow-through by helping students and families make good decisions and plan ways to deal with potential barriers.

A client oriented, user friendly referral intervention is built around recognition of the specific needs of those served and involves clients in every step of the process. That is, the intervention is designed with an appreciation of

- the nature and scope of student problems as perceived by students and their family
- differences among clients in terms of background and resources
- the ethical and motivational importance of client participation and choice.

Moreover, given that many clients are reluctant to ask for or follow-through with a referral, particular attention is paid to ways to overcome factors that produce reluctance.

Referral Intervention Guidelines

A referral intervention should minimally

- provide readily accessible basic information about all relevant sources of help
- help the student/family appreciate the need for and value of referral
- account for problems of access (e.g., cost, location, language and cultural sensitivity)
- aid students/families to review their options and make decisions in their own best interests
- provide sufficient support and direction to enable the student/family to connect with an appropriate referral resource
- follow-up with students (and with those to whom referrals are made) to determine whether referral decisions were appropriate.

These guidelines can be translated into a 9 step intervention designed to facilitate the referral process and maximize follow-through.

Steps*

Step 1

Provide ways for students and school personnel to learn about sources of help without having to contact you

This entails widespread circulation to students/families and staff of general information about available services on- and off-campus and ways students can readily access services.

Step 2

For those who contact you, establish whether referral is necessary

It is necessary if school policy or lack of resources prevent the student's problem from being handled at school.

Step 3

Identify potential referral options with the client

If the school cannot provide the service, the focus is on reviewing with the student/family the value and nature of referral options. Some form of a referral resource file is indispensable (see Appendix B for more on the idea of a Referral Resource File).

Step 4

Analyze options with client and help client choose the most appropriate ones

This mainly involves evaluating the pros and cons of potential options (including location and fees), and if more than one option emerges as promising, rank ordering them.

Step 5

Identify and explore with the client all factors that might be potential barriers to pursuing the most appropriate option

Is there a financial problem? a transportation problem? a parental or peer problem? too much anxiety/fear/apathy?

(cont.)

*Before pursuing such steps, be certain to review school district policies regarding referral (see Appendix B).

STEPS (cont.)

Step 6

Work on strategies for overcoming barriers

This often overlooked step is essential if referral is to be viable. It entails taking time to clarify specific ways the student/family can deal with factors likely to interfere with follow-through.

Step 7

*Send clients away with a written summary of what was decided**

That is, summarize

- specific information on the chosen referral,
- planned strategies for overcoming barriers,
- other options identified as back-ups in case the first choice doesn't work out.

Step 8

*Provide client with follow-through status forms**

These are designed to let the school know whether the referral worked out, and if not, whether additional help is needed in connecting with a service.

Step 9

*Follow-up with students/families (and referrers) to determine status and whether referral decisions were appropriate**

This requires establishing a reminder system to initiate a follow-up interview after an appropriate time period.

Obviously, the above steps may require one or more sessions.

If follow-up indicates that the client hasn't followed-through and there remains a need, the referral intervention can be repeated, with particular attention to barriers and strategies for overcoming them. Extreme cases may require extreme measures such as helping a family overcome transportation problems or offering to go with a family to help them connect with a referral.

*See Appendix C for examples of tools to aid these steps.

Providing Information about Services

Whether you are in a situation with few or many referral options, it is essential to compile and share basic information about all potential services (see Appendix B). A prerequisite for establishing and updating a good referral information system is to identify a staff member who will accept ongoing responsibility for the system.

Initially, such activity may take 3-4 hours a week. Maintaining the system probably requires only 1-2 hours per month. The staff member in charge of the system does not need to carry out all the tasks. Much of the activity can be done by a student or community volunteer or an aide.

In gathering information about services, the focus is on clarifying what is offered

- at the school site,
- elsewhere by school district personnel,
- in the local community,
- outside the immediate community.

If the school does not have a list of on-campus resources, a first step is to survey school staff and prepare a list of on-campus services dealing with psychosocial and mental health concerns (see Appendix B).

Similarly, information about other services offered by the school district can be gathered by calling relevant district personnel (e.g., administrators in charge of school psychologists, social workers, health services, special education, counseling).

In some geographic areas, public agencies (e.g., department of social services, libraries, universities) publish resource guidebooks which list major helplines, crises centers, mental health clinics, drug abuse programs, social service agencies, organizations offering special programs such as weight management, and so forth. Also, in some areas, telephone directories contain special sections on local Human Services.

Developing Ways to Facilitate Access to Service

In carrying out referral interventions to facilitate access to services, it is useful to develop

- materials listing the most accessible referrals and ways to circulate such materials widely,
- a comprehensive referral resource file,
- an array of procedures to support and direct students in following-through on referrals.
- And, it also may be useful to make personal contact with individuals at various agencies and programs as a way of opening doors for students referred from the school.

(1) *Highlighting the Most Accessible Referral Resources*

Once the most accessible referrals are identified, they can be listed and the lists can be widely circulated (see Appendix H for examples). Such listings might take the form of

- 1-2 page handouts,
- wallet-size handouts,
- program description flyers & posters.

To ensure widespread circulation, information on services first can be distributed to all school staff (preferably with a memo from the school administration clarifying the purposes and importance of referring students in need). A follow-up presentation at a school staff meeting is highly desirable.

For older students, staff can offer to make direct presentations -- at least in classrooms of teachers who play a key role in distributing such information to students (e.g., homeroom or health teachers).

Because of staff changes, new enrollments, and the need for reminders, service information materials might be circulated at least three times during the school year. If the school has a health fair, this provides an excellent opportunity for disseminating service information material along with other relevant pamphlets. Such information also might be published in student newspapers and parent newsletters and as part of periodic health exhibits in school display cases and in health, counseling, and other offices.

(2) ***Referral Resource Files***

A referral resource filing system is intended to contain a comprehensive compilation of basic information on available services (see Appendix B).

Sources for this information are published directories or material gathered directly from programs and agencies. For example, once identified, each service can be asked to provide all relevant program descriptions and information which can be filed alphabetically in separate folders.

Referral files are most useful when the basic information on available services also is categorized. Minimally, categorization should be by location and by the type of problems for which the service can provide help.

To further facilitate access, the information on each program can be briefly summarized and placed in a binder "Resource Notebook" for easy reference. Minimally, a program summary might itemize

- service fees (if any) and hours
- whether provision is made for clients who do not speak English
- specific directions to locations (if off-campus, it is helpful to specify public transportation directions).

Referral resource files should be located where interested students can use them on their own if they so desire. To facilitate unaided use, a set of simple directions should be provided, and files and "Resource Notebooks" need to be clearly labeled.

(3) ***Support and Direction for Follow-through***

Many students are uncertain or not highly motivated to follow-through with a referral; others are motivated to avoid doing so. If we are to move beyond the ritual of providing referrals which students ignore, time and effort must be devoted to procedures that increase the likelihood of follow-through.

This involves finding out:

Does the student agree that a referral is necessary? (See student interview form in Appendix A.)

If not, additional time is required to help the student explore the matter. Uncertain students often need more information and should be offered the opportunity to meet with someone (e.g., school counselor, nurse, psychologist) who can explain about available programs. This includes discussing concerns about parental involvement. If such exploration does not result in the student really wanting to pursue a referral, follow-through on her or his own is unlikely. The problem then is whether the student's problem warrants coercive action (e.g., recruiting parents to take the student to the service).

For students who do agree that referral is appropriate but still are not highly motivated to follow-through, intervention focuses on increasing their motivation and providing support as they proceed.

Student participation in the process of identifying and choosing referral options is seen as one key to increasing motivation for follow-through. Students who feel the choice of where to go is theirs are likely to feel more committed. This is a good reason for working closely with a student at each step in identifying referral options.

Another aspect of enhancing a student's resolve to pursue a referral involves clarifying and addressing any reluctance, concern, and barriers through

- careful exploration of such factors
- specification of strategies to deal with them.

At the conclusion of the referral session(s), a potential enabling device is to provide the student with

- a written summary of referral recommendations and strategies for overcoming barriers
- two follow-up feedback forms -- one for the student to return to the school and one for the referral agency to send back.

See Appendix C for examples.

Other major supports that might be offered students include

- helping them make initial phone contacts and appointments (including having the student talk directly with the person to be seen)
- providing specific directions and even transportation to the first appointment
- parents or staff accompanying a student to the first appointment
- following-up (as described in a subsequent section).

(4) ***Personal Contact with Referral Resources***

Some staff have found that their referrals receive better attention after they have established a personal relationship with someone in a program or at an agency.

They accomplish this by periodically phoning and visiting or inviting selected individuals to visit.

In addition to helping establish special relationships that can facilitate access for students referred by the school, these contacts also provide additional information for referral resource files.

When Can Students Seek Assistance without Parent Involvement?

Older students often want or need to access services without their parents knowing and with confidentiality protected. Where the law allows, licensed professionals can offer some sensitive services without parent consent. School-based health centers allow for open access once parents have signed an initial consent form that allows the student to use designated services.

In many instances, however, students are not in a position or motivated to follow-through with a referral -- even though their problems may be severe. Thus, more often than not, parent involvement is needed to facilitate follow-through. For example, students may need parents to pay fees and for transportation. If a student is not an emancipated minor, the referral resource will probably require parental consent.

When parent involvement is indicated, the referral intervention includes efforts to help students understand the benefits of such involvement and encourage them to discuss the matter with their parents. Staff can play a major role in facilitating and perhaps mediating a student-parent discussion for students who see the need but are fearful of approaching their parents without support.

What if a student is determined not to involve parents? Except when inaction would place the student or others in extreme danger, some staff prefer to honor a student's desire to maintain confidentiality. In such instances, the only course of action open is to offer whatever referral follow-through support the school can provide. Some staff, however, believe it essential for parents to take responsibility for student follow-through. Thus, parents are given referral information and asked to see that the student makes contact. Any needed follow-through support is directed at the parents.

(5) *Enhancing On-Campus Services*

It is given that referral to services offered on-campus ensures accessibility and generally increases follow-through. Therefore, efforts to expand on-campus resources are important to improving follow-through.

Additional on-campus resources can be accomplished by

- recruiting and training interested school personnel and students to offer appropriate services (e.g., mediating, mentoring, counseling)
- outreaching to convince appropriate agencies and professionals to offer certain services on-campus (e.g., arranging for on-campus substance abuse counseling by personnel from county mental health or a local community mental health clinic)
- outreaching to recruit professionals-in-training and professional and lay volunteers
- helping create new programs (e.g., stimulating interest in starting a suicide prevention program and helping train school staff to run it).

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CASE EXAMPLE

A 10th grader comes to see you because her home situation has become so distressful she cannot concentrate on her school work, and she is feeling overwhelmed. It's evident she needs support and counseling. Because the school cannot currently provide such services, she has to be referred elsewhere. Thus, it falls to someone at the school to implement a referral intervention. The immediate intervention might be conducted over two sessions, with a follow-up interview done 2 weeks later. The gist of the intervention might take the following form.

Session 1: *Sara, you've been very open in talking with me about the problems you're having at home. It sounds like some regular counseling appointments might help you sort things out.*

Right now, we can't provide what you need. Because it's important to take care of the problems you've told me about, I want to help you find someone who can offer what you need.

Let's look over what's available. (Referral Resource Files are used -- see Appendix B) *We have this information about local counseling resources. The first lists services provided by neighborhood agencies. There are two that might work for you. You said one of the problems is that your father drinks too much. As you can see, one local counseling center is doing a weekly group for Children of Alcoholics who want to talk about their troubles at home. And, on Wednesday afternoons, a social worker from a community center comes to the school to offer individual counseling.*

Not too far away is a counseling program offered by the school district. What might work for you is one of their counseling groups. These are offered on either Tuesday or Thursday after school at a place which is about 3 miles from here.

The program offered here at the school and the one provided by the school district are free; the one at the local counseling center charges a fee of $5 for each session. Both the school district's program and the local counseling center are on the bus line so you could get there on your own.

Why don't you take tonight to think about what might work best for you and maybe make a list of concerns you have that we should talk about. Think about how you feel about meeting with a counselor alone or working with other students in a support group. You may want to talk to your parents before you decide, but you don't have to. However, if you do want counseling, your parents will have to give their consent.

Let's meet again tomorrow to discuss your options and how I can help you make your decision.

(cont. on next page)

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CASE EXAMPLE (cont.)

The second session focuses on Sara's (a) anxiety about telling her father she wants to sign up for counseling, (b) concerns about whether to join a group, and (c) preference not to go to an off-campus service. Any other barriers that might hinder follow-through also are worked on.

[After the various pros and cons are discussed and Sara seems to be favoring a particular option . . .]

Session 2: *So it sounds as if you'd like to see the social worker who comes to campus every Wednesday. We should put that down as your first choice. You also said the Children of Alcoholics group might be worth checking out -- let's put that down as a second choice. . . . And as we agreed, I'll be glad to meet with you and your parents to help you explain that such counseling will be a good thing for you.*

Let's call your parents now and set up an appointment. . . . Tomorrow, you can call the social worker and make an appointment to talk about signing up for a regular counseling time. . . . If you have trouble with any of this, remember to come back to see me for help.

I've written all this down; here's your copy. (See Appendix A.) *I'd also like you to let me know how our plans work out. Here's a form for you to return to me; all you have to do is put a check mark to let me know what happened and then drop the form in the school mail box sometime next week.* (See Appendix C.)

Also, unless you need to come see me before then, I'll be checking with you in two weeks to see how things worked out.

Follow-up Interview: A "tickler" system (e.g., a notation on a calendar) is set up to provide a daily case monitoring reminder of who is due for a Follow-up Interview (discussed on the next page). The interview explores:

Has Sara been able to connect with her first or second choices?

If not, why not? And, how can she be helped to do so?

If she has made contact, does it now seem like the right choice was made? If not, the reasons why need to be clarified and additional options explored.

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Following-Up on Referrals (including consumer feedback)

Follow-through for most referrals is meant to occur within a two week period. Thus, a good referral system should have a process in place that regularly reviews the status of students who were given referrals three weeks earlier.

The elements of such a system might include

- feedback forms given to clients for themselves and the referral agency (see Appendix D)
- a feedback form sent directly to the referral of first choice
- a procedure for daily identification of students due for referral follow-up
- analysis of follow-through status based on feedback
- follow-up interviews with students/families for whom there is no feedback information (See Appendix D).

For example:

As part of referral intervention, students/families can be given two types of feedback follow-up forms. In addition, a "back-up" feedback form can be sent directly to the service the student has identified as a first choice.

The client is to return a form to the school to show that contact was made with the referral agency or to clarify why such contact was not made. In either instance, the form reminds the student/family to return for additional referral help if needed.

If contact was made, the student/family might be asked to indicate whether the service seems satisfactory. For anyone who indicates dissatisfaction, the school may want to discuss the matter to determine whether another option should be pursued. If many clients indicate dissatisfaction with a particular agency, it becomes clear that it is not a good resource and should be removed from the referral listings.

The feedback form sent directly to the chosen service simply calls for a confirmation of follow-through. (With on-campus referrals, it has been found useful to establish a reciprocal feedback system. (See Appendix D.)

If no feedback forms are returned, the student can be invited to explore what happened and whether additional support and direction might help.

Section III

Managing *Care*, Not *Cases*

Initial Monitoring of Care

Ongoing Management of Care

Systems of Care

MANAGING *CARE*, NOT *CASES*

"To take care of them"
can and should be read
with two meanings:
to give children help
and to exclude them
from the community.
Nicholas Hobbs

Embedded within the meaning of care that emphasizes help also is caring. Many professionals have suggested that a sense of caring is crucial if programs and services are to be successful in helping youngsters.

> In this discussion of management of care, the assumptions are that the intent is to help and the method should convey a sense of caring.

To avoid undermining these points, the word "case" (as in case management) is replaced with the term *care*.

> Management of care involves (1) initial monitoring, (2) ongoing management of an individual's prescribed assistance, and (3) system's management.

As with any intervention, these activities must be implemented in ways that are developmentally and motivationally appropriate, as well as culturally sensitive.

Initial Monitoring of Care

Stated simply, monitoring of care is the process by which it is determined whether a client is appropriately involved in prescribed programs and services. Initial monitoring by school staff focuses on whether a student/family has connected with a referral resource.

All monitoring of care requires systems that are designed to gather information about follow-through and that the referral resource is indeed turning out to be an appropriate way for to meet client needs (see Appendix D).

When a client is involved with more than one intervener, management of care becomes a concern. This clearly is always the situation when a student is referred for help over and above that which her/his teacher(s) can provide.

Subsequent monitoring as part of the ongoing management of client care focuses on coordinating interventions, improving quality of care (including revising intervention plans as appropriate), and enhancing cost-efficacy.

Ongoing Management of Care

Management of care involves a variety of activity all of which is designed to ensure that client interests are well-served. At the core of the process is enhanced monitoring of care with a specific focus on the appropriateness of the chosen interventions, adequacy of client involvement, appropriateness of intervention planning and implementation, and progress.

Such ongoing monitoring requires systems for

- *tracking client involvement in interventions*
- *amassing and analyzing data on intervention planning and implementation*
- *amassing and analyzing progress data*
- *recommending changes*

Effective monitoring depends on information systems that enable those involved with clients to regularly gather, store, and retrieve data. Schools rely heavily on forms for gathering necessary information (see appendices). In coming years, more and more of this information will be entered into computers to facilitate retrieval and assist in other ways with client care.

Management of care, of course, involves more than monitoring processes and outcomes. Management also calls for the ability to produce changes as necessary.

Sometimes steps must be taken to improve the quality of processes, including at times enhancing coordination among several interveners. Sometimes intervention plans need to be revised to increase their efficacy and minimize their "costs" -- including addressing negative "side effects." Thus, management of care involves using the findings from ongoing monitoring to clarify if interventions need to be altered and then implements strategies to identify appropriate changes and ensure they are implemented with continued monitoring. Along the way, those involved in managing the client's care may have to advocate for and broker essential help and provide the linkage among services that ensures they are coordinated. They also must enhance coordinated intervener communication with the student's caregivers at home.

> Who does all this monitoring and management of care? Ideally, all involved parties -- interveners and clients -- assume these functions and become the *management team.* One member of such a team needs to take *primary* responsibility for management of care (a *primary manager*). Sites with sufficient resources often opt to employ one staff member to fill this role for all clients. However, given the limited resources available to schools, a more practical model is train many staff to share such a role. Ultimately, with proper instruction, one or more family members might be able to assume this role.

All who assume the role or primary care manager must approach it in a way that respects the client and conveys a sense of caring. The process should be oriented to problem-solving but should not be limited to problem treatments (e.g., in working on their problems, young people should not be cut off from developmental and enrichment opportunities). In most instances, a youngster's family will be integrally involved and empowered as partners, as well as recipients of care.

> Unfortunately, there are times when a client is forced to enrol and/or remain in a program (e g., mandated counseling, diversion programming). By definition, such intervention eliminates client choice and self-determination and is likely to be experienced as disempowering. Clients in such situations can be expected to manifest various forms of reactive behavior. The challenge for all interveners in these instances is one of overcoming negative motivation by finding ways the client can regain their sense of self-determination. The primary care manager can assist in meeting this need by inviting the client's participation in all subsequent team reviews and decision making.

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Well-implemented management of care can help ensure that clients are helped in a comprehensive, integrated manner that addresses her/him as a whole person. A positive side effect of all this can be enhancement of systems of care.

Management teams need to meet whenever analysis of monitoring information suggests a need for program changes or at designated review periods. Between meetings, it is the responsibility of the primary manager to ensure care is appropriately monitored and team meetings are called whenever changes are needed. It is the team as a whole, however, that has responsibility for designating necessary changes and working to ensure designated changes are made.

A few basic guidelines for primary managers of care are

- write up analyses of monitoring findings and recommendations to share with management team;
- immediately after a team meeting, write up and circulate changes proposed by management team and emphasize who has agreed to do which tasks by when (see Appendix D);
- set-up a "tickler" system (e.g., a notation on a calendar) to remind you when to check on whether tasks have been accomplished;
- follow-up with team members who have not accomplished agreed upon tasks to see what assistance they need.

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Advanced Technology to Assist with Student Care

School sites with health or family service centers already have entered the age of computer assistance in providing care for students and their families. Constantly evolving systems are available not only to facilitate record keeping and reporting, but to aid with assessment and consultation, referrals, program planning, and ongoing management of care. As schools and other agencies move to computerized information systems, the capacity for integration and networking will be greatly enhanced.

For example, schools and community agencies will have the opportunity to share relevant information in ways that protect client privacy and enhance collaborative intervention. The advanced technology will also allow for rapid updating of information about available services, and school staff will be able to help students/families sign-up on-line. Computer technology also can be used as another modality to enhance counseling and therapy.

Beyond enhancing efforts to treat problems, the advanced technology opens up new avenues for students and parents to seek out information for themselves and connect with others for support.

Of course, as with any tool, computer software varies in quality and can be misused. For instance, reliance on computer programs to generate diagnoses will predictably exacerbate current trends to overuse psychopathological diagnoses in identifying mild-to-moderate emotional, learning, and behavior problems.

Similarly, there is a danger that schools will develop their computerized information and computer-assisted intervention systems in a fragmented and piecemeal manner. This will result in a waste of scarce resources and will reduce the usefulness of what is potentially an extremely powerful aid in efforts to address barriers to student learning and enhance healthy development.

References

Marzke, C. (1995). *Information systems to support comprehensive, integrated service delivery and sustainability.* Sacramento, CA: Walter MacDonald & Associates (916) 427-1410.

Thornburg, D. (1991). *Education, technology, and paradigm changes for the 21st century.* Starsong Pub.

Systems of Care

The concept of a "system of care" is an evolving idea that is applied in a variety of ways. While management of care is focused on a given client, the concept of systems of care emphasizes the importance of coordinating, integrating, and enhancing systems and resources to ensure that appropriate programs are available, accessible, and adaptable to the needs of the many clients who need help. Moreover, the aim is to ensure these resources are used effectively and efficiently.

> A focus on system resources requires attending to various arenas and levels of potential support. A school has many programs and services that it owns and operates. A school district has additional resources. The surrounding community usually has public and private sector programs and a variety of other resources that may be of assistance. City, county, and state agencies also play a role in addressing certain needs.

In its initial application, the concept of systems of care focused on services to address clients with severe and well-established problems (e.g., youngsters with serious emotional disturbance). The intent of systems of care for such populations is to

- develop and provide a full array of community-based programs (including residential and non-residential alternatives to traditional inpatient and outpatient programs) to enhance what is available and reduce overreliance on out-of-home placements and overly restrictive treatment environments;

- increase interagency collaboration in planning, developing, and carrying out programs to enhance efficacy and reduce costly redundancy;

- establish ways that interventions can be effectively adapted to the individuals served.

To expand these goals to encompass prevention, there are increasing calls for incorporating primary and secondary prevention programs into all systems of care.

At school sites, one mechanism for focusing on enhancing systems of care is a Resource Coordinating Team. Such a team is designed to bring together representatives from all major programs and services addressing barriers to learning and promoting healthy development (e.g., pupils services personnel, a site administrator, special education staff, bilingual coordinators, health educators, noncredentialed staff, parents, older students). It also includes representatives from community agencies that are significantly involved at a school.

A Resource Coordinating Team differs from teams created to review individual students (such as a student study team) because it focuses on managing and enhancing *systems* to coordinate, integrate, and strengthen interventions. At the same time, many of the same staff usually are on both types of teams. Thus, initial creation of a Resource Coordinating Team often is best accomplished by broadening the scope of a student study team (or a teacher assistance team or a school crisis team). In doing so, however, it is essential to separate the agenda and have the members change "hats."

A Resource Coordinating Team works toward weaving together all school and community programs and services. Among its activities, the team

- conducts resource mapping and analysis with a view to improving resource use and coordination
- ensures that effective systems are in place for triage, referral, management of care, and quality improvement
- establishes appropriate procedures for effective program management and for communication among school staff and with the home
- suggests ways to reallocate and enhance resources (e.g., clarifying how to better use staff and resources, which activities need revision or are not worth continuing).

Properly constituted, trained, and supported, a Resource Coordinating Team can complement the work of the school's governance body through providing on-site overview, leadership, and advocacy for activities aimed at addressing barriers to learning and enhancing healthy development. To these ends, at least one team member should be designated as a liaison between the team and the school's governing and planning bodies to ensure the maintenance, improvement, and increased integration of essential programs and services with the total school program.

Because they often deal with the same families (e.g., families with children at each level of schooling) and link with the same community resources, complexes of schools (a high school and its feeder middle and elementary schools) should work collaboratively. A Complex Resource Coordinating *Council* brings together representatives from each school's Resource Coordinating Team to facilitate coordination and equity among schools in using school and community resources.

Accounting for Cultural, Racial, and Other Significant Individual and Group Differences

All interventions to address barriers to learning and promote healthy development must consider significant individual and group differences.

In this respect, discussions of diversity and cultural competence offer some useful concerns to consider and explore. For example, the Family and Youth Services Bureau of the U.S. Department of Health and Human Services, in a 1994 document entitled *A Guide to Enhancing the Cultural Competence of Runaway and Homeless Youth Programs*, outlines some baseline assumptions which can be broadened to read as follows:

> Those who work with youngsters and their families can better meet the needs of their target population by enhancing their competence with respect to the group and its intragroup differences.
>
> Developing such competence is a dynamic, on-going process -- not a goal or outcome. That is, there is no single activity or event that will enhance such competence. In fact, use of a single activity reinforces a false sense of that the "problem is solved."
>
> Diversity training is widely viewed as important, but is not effective in isolation. Programs should avoid the "quick fix" theory of providing training without follow-up or mor concrete management and programmatic changes.
>
> Hiring staff from the same background as the target population does not necessarily ensure the provision of appropriate services, especially if those staff are not in decision-making positions, *or* are not themselves appreciative of, or respectful to, group and intragroup differences.
>
> Establishing a process for enhancing a program's competence with respect to group and intragroup differences is an opportunity for positive organizational and individual growth.

The Bureau document goes on to state that programs:

> are moving from the individually-focused "medical model" to a clearer understanding of the many external causes of our social problems ... why young people growing up in intergenerational poverty amidst decaying buildings and failing inner-city infrastructures are likely to respond in rage or despair. It is no longer surprising that lesbian and gay youth growing up in communities that do not acknowledge their existence might surrender to suicide in greater numbers than their peers. We are beginning to accept that social problems are indeed more often the problems of society than the individual.
>
> These changes, however, have not occurred without some resistance and backlash, nor are they universal. Racism, bigotry, sexism, religious discrimination, homophobia, and lack of sensitivity to the needs of special populations continue to affect the lives of each new generation. Powerful leaders and organizations throughout the country continue to promote the exclusion of people who are "different," resulting in the disabling by-products of hatred, fear, and unrealized potential.
>
> ... We will not move toward diversity until we promote inclusion ... Programs will not accomplish any of (their) central missions unless ... (their approach reflects) knowledge, sensitivity, and a willingness to learn.

In their discussion of "The Cultural Competence Model," Mason, Benjamin, and Lewis* (1996) outline five cultural competence values which they stress are more concerned with behavior than awareness and sensitivity and should be reflected in staff attitude and practice and the organization's policy and structure. In essence, these five values are

(1) *Valuing Diversity* -- which they suggest is a matter of framing cultural diversity as a strength in clients, line staff, administrative personnel, board membership, and volunteers.

(2) Conducting Cultural Self-Assessment -- to be aware of cultural blind spots and ways in which one's values and assumptions may differ from those held by clients.

(3) *Understanding the Dynamics of Difference* -- which they see as the ability to understand what happens when people of different cultural backgrounds interact.

(4) *Incorporating Cultural Knowledge* -- seen as an ongoing process.

(5) *Adapting to Diversity* -- described as modifying direct interventions and the way the organization is run so that they reflect the contextual realities of a given catchment area and the sociopolitical forces that may have shaped those who live in the area.

*In *Families and the Mental Health System for Children and Adolescents*, edited by C.A. Heflinger & C.T. Nixon. CA: Sage Publications.

A Few References Related to Management of Care

Adelman, H. S. (1996). *Restructuring education support services: Toward the concept of an enabling component.* Kent, OH: American School Health Association.

Adelman, H. S. & Taylor, L. (in press). System reform to address barriers to learning: Beyond school-linked services and full service schools. *American Journal of Orthopsychiatry.*

Ballew, J. R. & Mink, G. (1986). *Case management in the human services.* Springfield, IL: Thomas.

Center for Mental Health in Schools (1996). *Policies and practices for addressing barriers to student learning: Current status and new directions.* Los Angeles, CA: Author. Available by contacting the Center at the Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563.

Hoagwood, K. & Koretz, D. (1996), Embedding prevention services within systems of care: Strengthening the nexus for children. *Applied & Preventive Psychology, 5,* 225-234

Marks, E. L., Maurer, K. E., & Simkin, L. S. (1994). *Case management in service integration: An annotated bibliography.* NY: National Center for Children in Poverty and the National Center for Service Integration.

Moxley, D. P. (1989). T*he practice of case management.* Thousand Oaks, CA: Sage Pub.

Parker, M., Quinn, J., Viehl, M., McKinley, A., Polich, C. L., Detzner, D. F., Hartwell, S., Korn, K. (1990). Case management in rural areas: Definition, clients, financing, staffing, and service delivery issues. *Nursing Economic$, 8,* 103-109.

Raiff, N. R., & Ostrosky, R. M. (1992). *Children & adolescent case management: An annotated bibliography (1987-1991).* Prepared for Southern Human Resource Development Consortium for Mental Health by the Office of Educational and Regional Planning, University of Pittsburgh Medical Center.

Rosenblum, L. DiCecco, M. B., Taylor, L., & Adelman, H. S. (1995). Upgrading school support programs through collaboration: Resource Coordinating Teams. *Social Work in Education, 17,* 117-124.

Taylor, L. & Adelman, H. S. (1996). Mental health in the schools: Promising directions for practice. *Adolescent Medicine: State of the Art Reviews, 7,* 303-317.

Stowitschek, J. J. & Smith, A. J. (1990). *Implementing the C-STARS interprofessional case management model for at-risk children.* Seattle, WA: University of Washington, Center for the Study and Teaching of AT-Risk Students. ERIC Document Reproduction Service No. ED 333-307.

The Center for Human Resources at Brandeis University developed several guides on the topic of case management for at-risk youth. Contact: the Center's director, Susan Curnan at Brandeis University, P.O. Box 9110, 60 Turner St. Waltham, MA 02254-9110 -- (617) 736-3770.

Appendices

Examples of Resource Materials and Procedures

In this appendix, you will find materials to aid in (1) the triage process, (2) establishing a system to provide clients with ready access to information about referral resources, (3) assisting client referrals, and (4) assuring quality of care.

A. Tools to Facilitate *Triage*

1. Triage Review Request Form
2. Student's View of the Problem -- Initial Interview Forms

B. Tools to Enhance *Client Access to Information on Referral Resources*

1. Examples of Resource Information Handouts for Students/Families
2. Description of Referral Resource Files
3. Example of One District's Referral Policy

C. Tools to *Assist Clients with Referrals*

1. Referral Decisions -- Summary Form
2. Guidelines and Follow-up Forms to Aid Referral Follow-through

D. Tools to Aid in *Assuring Quality of Care*

1. Follow-up Rating Forms -- Service Status
2. Management of Care Review Form

Appendix A

Tools to Facilitate *Triage*

Two aids are provided here:

1. *Triage Review Request Form*

2. *Student's View of the Problem -- Initial Interview Forms*
   - form for use with all but very young children
   - form for use with very young children

Note. The Center's Resource Aid Packet on *Screening/Assessment: Indicators and Tools* contains related materials such as aids for initial problem identification and guides to understanding the screening process.

Triage Review Request Form
(Request for Assistance in Addressing Concerns about a Student/Family)

Extensive assessment is not necessary in initially identifying a student about whom you are concerned. Use this form if a student is having a *significant* learning problem, a *major* behavior problem, or seems *extremely* disturbed or disabled.

Student's Name _____ Date: _____

To: _____ Title: _____

From: _____ Title: _____

Apparent problem (check all that apply):

___ physical health problem (specify) _____

___ difficulty in making a transition
( ) newcomer having trouble with school adjustment ( ) trouble adjusting to new program

___ social problems
( ) aggressive ( ) shy ( ) overactive ( ) other _____

___achievement problems
( ) poor grades ( ) poor skills ( ) low motivation ( ) other _____

___ major psychosocial or mental health concern

( ) drug/alcoh. abuse	( ) pregnancy prevention/support	( ) self esteem
( ) depression/suicide	( ) eating problems (anorexia, bulim.)	( ) relationship problems
( ) grief	( ) physical/sexual abuse	( ) anxiety/phobia
( ) dropout prevention	( ) neglect	( ) disabilities
( ) gang involvement	( ) reactions to chronic illness	

Other specific concerns

Current school functioning and desire for assistance

Overall academic performance
( ) above grade level ( ) at grade level ( ) slightly below grade level ( ) well below grade level

Absent from school
( ) less than once/month ( ) once/month ( ) 2-3 times/ month ( ) 4 or more times/month

Has the student/family asked for:

information about service	Y	N
an appointment to initiate help	Y	N
someone to contact them to offer help	Y	N

If you have information about the cause of a problem or other important factors related to the situation, briefly note the specifics here (use the back of the sheet if necessary).

(For use with all but very young students)

Student's View of the Problem -- Initial Interview Form

Interviewer _____ Date_____

Note the identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

_____

Questions for student to answer:

Student's Name _____ Age ____ Birthdate _____

Sex: M F Grade _____ Current Placement _____

Ethnicity _____ Primary Language _____

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) How would you describe your current situation? What problems are you experiencing? What are your main concerns?

(2) How serious are these matters for you at this time?

1	2	3	4
very serious	serious	Not too serious	Not at all serious

(3) How long have these been problems?

___ 0-3 months ___4 months to a year ____more than a year

(4) What do you think originally caused these problems?

(5) Do others (parents, teachers, friends) think there were other causes?
If so, what they say they were?

(6) What other things are currently making it hard to deal with the problems?

(7) What have you already tried in order todeal with the problems?

(8) Why do you think these things didn't work?

(9) What have others advised you to do?

(10) What do you think would help solve the problems?

(11) How much time and effort do you want to put into solving the problems?

1	2	3	4	5	6
not at all	not much	only a	more than little bit	quite a bit a little bit	very much

If you answered 1, 2, or 3, why don't you want to put much time and effort into solving problems?

(12) What type of help do you want?

(13) What changes are you hoping for?

(14) How hopeful are you about solving the problems?

1	2	3	4
very hopeful	somewhat	not too	not at all hopeful

If you're not hopeful, why not?

(15) What else should we know so that we can help?

Are there any other matters you want to discuss?

(For use with very young students)

Student's View of the Problem -- Initial Interview Form

Interviewer _____ Date_____

Note the identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

_____

Questions for student to answer:

Student's Name _____ Age _____ Birthdate _____

Sex: M F Grade _____ Current Placement _____

Ethnicity _____ Primary Language _____

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) Are you having problems at school? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(2) How much do you like school?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about school don't you like?

What can we do to make it better for you?

(3) Are you having problems at home? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(4) How much do you like things at home?

1	2	3	4	5	6
not at all	not much	only a	more than a little bit	Quite a bit little bit	Very much

What about things at home don't you like?

What can we do to make it better for you?

(5) Are you having problems with other kids? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(6) How much do you like being with other kids?

1	2	3	4	5	6
not at all	not much	only a	more than a little bit	Quite a bit little bit	Very much

What about other kids don't you like?

What can we do to make it better for you?

(7) What type of help do you want?

(8) How hopeful are you about solving the problems?

1	2	3	4
very hopeful	somewhat	not too	not at all hopeful

If you're not hopeful, why not?

(9) What else should we know so that we can help?

Are there any other things you want to tell me or talk about?

Appendix B

Tools to Enhance
Client Access to Information on Referral Resources

Three aids are provided here:

1. *Examples of Resource Information Handouts for Students/Families*

2. *Description of Referral Resource Files*

3. *Example of One District's Referral Policy*

Examples of Resource Information Handouts for Students/Families

This and the following pages offer format examples of materials developed to provide students, families, and staff with ready references to key referral resources. It is best if these references are backed up with a Referral Resource File containing summary descriptions and other information on the various services.

ON-CAMPUS MENTAL HEALTH RESOURCES

GENERAL PSYCHOSOCIAL PROBLEMS

Clinic Mental Health Professional -- (name)
information, screening, referral, individual and group therapy, crises, consultation, supervises interns and volunteer professionals offering individual and group psychotherapy

School Nurse -- (name)
information, screening, referral, consultation, supervises interns and volunteer professionals offering individual and group counseling

Clinic Nurse Practitioner -- (name)
information, screening, referral, consultation

School Psychologist -- (name)
information, screening, assessment, referral, individual and group counseling, crises, consultation -- primary focus on special education but available on a limited basis for regular education students

School Counselors
information, screening, and referral

Student Assistance Center -- (name)
information, screening, referral, coordination and facilitation of counseling and self-help groups, training and coordination of peer counselors, consultation

SPECIAL PROBLEM FOCUS

Substance Abuse
Counselor -- (names)
information, screening, referral, treatment, consultation

Psychosocial Problems Resulting from Pregnancy
Counselors from an outside agency who come to the school -- (names)
individual and group counseling, consultation

Teacher for pregnant minors class -- (name)
education, support, consultation

Infant Center -- (name)
education, support, consultation

Dropout Prevention
Advisor -- (name)
individual and group counseling, consultation

RELATED CONCERNS

Clinic Health Educator -- (name)
offers and educational focus in dealing with various problems (e.g., weight problems)

Vocational Educational Advisor -- (name)
job counseling and finding for special education students

COMMUNITY COUNSELING RESOURCES

The community resources listed below are provided to assist in finding community services. The School District does not assume responsibility for the services provided nor for the fees that may be charged.

Individual, Group, and Family Counseling

Hathaway Childrens Serv.
11600 Eldridge Ave.
Lake View Terr., 91342
(818) 896-1161 Ext. 231

San Fernando Valley
Child Guidance Clinic
9650 Zelzah
(818) 993-9311

El Nido Services
12502 Van Nuys Blv
Pacoima, 91331
(818) 896-7776

Manos Esperanza
14412 Hamlin
Van Nuys, 91405
(818) 376-0028
(818) 780-9727

Boys & Girls Club
of San Fernando
11251 Glenoaks Blvd
Pacoima, 91331
(818) 896-5261

Families Anonymous
(818) 989-7841

North Valley Family
Counseling Center
661 S. Workman St.
San Fernando, 91340
(818) 365-5320

Because I Love You
General Information Line
(818) 882-4881

Sons & Daughters United/
Parents United
Sexually Abused Children (13-18)
Intake: M & T, 1-4:30
(213) 727-4080

Drug Programs

El Proyecto del Barrio
13643 Van Nuys Blvd.
Pacoima, 91331
(818) 896-1135

Life-Plus
6421 Coldwater Canyon
North Hollywood, 91606
(818) 769-1000

Vista Recovery Center
7136 Haskell Ave.
Van Nuys, 91406
(818) 376-1600

ASAP - Panorama City Hosp.
14850 Roscoe Blvd.
Van Nuys, 91406
(818) 787-2222

IADARP - Reseda
(818) 705-4175

Phone Counseling

Valley Hotline
(818) 989-5463

Suicide Prevention
(213) 381-5111

Alateen
(213) 387-3158

Helpline Youth Counseling
(213) 864-3722

Spanish Bilingual Helpline
(818) 780-9727

Info Line
(818) 501-4447

Child Abuse Hotline
Dial 0 -- Ask for
Zenith 2-1234

Rape Hotline
(818) 708-1700

Runaway
1-800-843-5200

Emergency Counseling

Crisis Management Center
Same day appointments
8101 Sepulveda Blvd.
Van Nuys, 91402
(818) 901-0327 or 782-1985

Olive View Mid-Valley Hospital
14445 Olive Drive
Sylmar 91342
(818) 364-4340 24 hours

FOR ADDITIONAL RESOURCES, SEE THE SCHOOL'S RESOURCE REFERENCE FILE

Example of a Wallet-Card Developed at a School Site for Students to Carry with Them

San Fernando High School

Community Resources

Alcohol & Other Drugs

Alcoholics Anonymous.....1-800-252-6465
Be Sober
24-hour hotline.....1-800-BE SOBER
Cocaine Anonymous.....(818) 988-1777
Narcotics Anonymous.....(818) 750-3951
El Projecto del Barrio.....(818) 896-1135

Suicide Prevention

Hotline for teens.....1-800-621-4000
24-hour Crisis.....(213) 381-5111

Child Abuse

Hotline.....1-800-272-6699
Family 24-hour
Crisis Center.....(818) 989-3157

Rape

Rape Hotline.....(818) 793-3385
Victims Anonymous.....(818) 993-1139

Run-Away

Run-away Hotline.....1-800-621-4000
L.A. Youth Network.....(213) 466-6200
Stepping Stone.....(213) 450-7839

Pregnancy/Family Planning

Pregnancy Testing.....(818) 365-8086
El Nido Services.....(818) 896-7776
L.A. County Health
Department.....(818) 896-1903

Other Resources

S.F.H.S. Teen
Health Clinic.....(818) 365-7517
Teenline.....1-800-TLC-TEEN
Aids Hotline.....1-800-922-2437
Spanish Bilingual Helpline..(818) 780-9727
Family Problems Group.....(818) 882-4881

BEST COPY AVAILABLE

Description of Referral Resource Files

A comprehensive referral resource filing system is built up in stages. The first stage involves a focus on a few key referrals. Each week, time can be devoted to adding a few more possible services. Once the main services are catalogued, only a little time each week is required to update the system (e.g., adding new services, deleting those that are not proving useful, updating information).

The tasks involved in establishing and maintaining the system can be described as follows:

1. Use available resource systems and directories and contact knowledgeable persons at the school and in the community to identify all possible services.

2. If sufficient information is available from directories and other systems, it can simply be photocopied. In cases where there is insufficient or no information, contact the service (preferably by mail) to request brochures and other materials that describe available services.

3. Use a standard format to summarize basic information for quick review (see attached form). The summary can be done by someone at the center abstracting information that has been gathered about a service or the form itself can be sent to be filled out by someone at the agency and returned.

4. Put the information gathered about each service into a separate folder and label the folder appropriately (e.g., name of agency or program).

5. Sort folders into categories reflecting (a) their location (e.g., on-campus, community-based) and (b) the type of service provided (e.g., counseling/ psychotherapy, substance abuse, vocational guidance, tutoring). File the folders alphabetically, by category in a filing cabinet that can be made accessible to clients.

6. Summaries can be exhibited in binder notebooks for quick review. Using separate binder "Resource Notebooks" for each location (e.g., on-campus, community-based), alphabetically insert the summaries into sections labeled for each category of service. There are computerized systems that can be used to store the information for easy access.

7. Files and Resource Notebooks should be put in an area where anyone interested in using them can have ready access. A poster might be hung over the file to call attention to this service information system and how to use it.

8. Listings of the most accessible services can be compiled and widely distributed to all school staff and students.

9. Consumer feedback can be elicited in a variety of ways from student users (e.g., as part of referral follow-through interviews or periodic consumer feedback questionnaires). If clients provide positive feedback on services, their comments can be included in the folders as an encouragement to others. If a number of clients indicate negative experiences with a service, it can be removed from the files.

10. Service listings and filed information and summaries regarding services probably should be updated yearly.

SUPPLEMENT TO BROCHURE AND OTHER PRINTED MATERIAL

Along with whatever brochures and printed material that is available, it is helpful to have a summary statement highlighting the following matters.

1. What is the particular philosophical or theoretical orientation underlying the service(s) provided?

2. Please describe the nature of what a client can expect to experience (e.g., time involvement, activities; if groups are involved, indicate typical group size and composition).

3. Specific directions for traveling to the service provider (e.g., using public transportation if off-campus).

4. If there is any other information that should be highlighted for a potential client, please provide it here.

Date this form was filled out: _____

SUMMARY SHEET ON AN AVAILABLE REFERRAL RESOURCE

The following is basic information provided by an agency and summarized here as a quick overview for anyone interested in the service.

How to contact the service

Name: _____ Phone: _____

Address: _____ City _____

Person to contact for additional information or to enroll in the service:

Name: _____ Title: _____

Clients served

Age range: Youngest _____ Oldest _____
Sex: Males _____ Females _____

Type of problems for which services are offered:
(please briefly list)

Ability to serve clients who do not speak English. YES NO
If so, which languages?

If there are any limitations or restrictions related to clients served, please note (e g , no individuals who are on drugs; only Spanish speaking).

Type of services **Fees:**
(please check services offered)

_____ Assessment _____
_____ Counseling/psychotherapy _____
_____ substance abuse treatment _____
_____ sexual abuse support groups _____
_____ vocational guidance _____
_____ tutoring _____
other (specify)
_____ _____ _____
_____ _____ _____
_____ _____ _____

Sliding Scale? YES NO

If there are any other sources that underwrite fees for the above services, please indicate them (e.g., public agencies, insurance).

Example of One School District's Referral Policy

INTRODUCTION

It is the policy of the District to initiate the referral of parents and pupils to appropriate agencies when a pupil's needs are beyond the scope and/or responsibility of school and District resources. School staff members cooperate with agency personnel in effecting timely and suitable referrals and work together on a continuing basis regarding aspects of the pupils problems which may relate to school adjustment. The following guidelines are to be followed in making such referrals.

I. SCHOOL PERSONNEL RESPONSIBLE FOR REFERRALS

A. The school principal or designee assumes administrative responsibility for the coordination of efforts to help a pupil in the school and for the delegation of community agency referrals to appropriate personnel.

B. Pupil services personnel are trained specifically to assist school staff and parents in the selection and contact of approved community resources providing counseling, health, mental health, and related services.

C. School staff and parents are encouraged to consult with the pupil services personnel assigned to the school for information and assistance in processing referrals (e.g., nurses, counselors, school physicians, psychologists, social workers).

II. SELECTION OF AGENCIES

A. Referrals may be made to:

1. Public tax supported agencies
2. Charitable support based agencies such as those funded under United Way
3. Voluntary non-profit agencies meeting the following criteria:
    a. Directed by a rotating board broadly representative of the community
    b. Not operated on fees alone
    c. Available on a sliding-scale cost to patients
    d. Open to the public without regard to color, race, religion ancestry, or country of natural origin
    e. Licensed by the State Department of Health when mental health services are involved.

B. Referrals shall not be made to:

1. A profit or non-profit proprietary agency. (proprietary: "held in private ownership")
2. Private practitioners or groups of private practitioners.

C. Since the District does not have staff resources to investigate the status or otherwise evaluate community agencies, school personnel should limit referrals to agencies listed by (designated resource book or public information phone or on-line service).

III. PROCESSING OF REFERRALS

A. Most health, counseling and related social service agencies require that the pupil, parent, or guardian make direct application for service. This does not preclude school personnel from assisting in the application process nor from presenting pertinent information to the agency in support of the applicant's request, when authorized by the parent.

B. Complete information about a recommended agency should be given to prospective clients by support services personnel. Such information should include agency program, application procedures, intake process, location, agency hours, telephone number, fees, and other pertinent data.

C. In all agency referrals, consideration should be given to family factors such as:
   1. Geographical area
   2. Determined needs and services
   3. Religious preference
   4. Ethnic and/or language factors
   5. Financial capability

D. A family's financial resources should be explored discreetly prior to making an appropriate agency referral. A family which has the financial ability to secure private services should consult with the family physician or the referral services provided by professional associations. A family which has its own insurance plan should confer with the plan's insurance consultant.

IV. RELEASE OF PUPIL INFORMATION

Written authorization from parent, guardian, or student (if student is eighteen [18] years of age and living independently of parents, or is an emancipated minor) must be obtained before any school information is released to a community agency regarding a pupil. The same such authorization is required for a community agency to release information to school personnel.

Status of Referral Follow-Through

Student's Name: _____ Today's Date:_____

____ I was unable to connect with any of the services we discussed.

____ I did connect with (write in the name of the service)

_____

Whether or not you connected with a service, you may want an additional session to discuss your service needs. If so, let us know by checking the following. We will then set up an appointment for you.

____ I would like another session to discuss my needs.

Status of Referral Follow-Through

TO:

FROM:

We recently referred _____ to you.

As part of our case monitoring, we would appreciate your letting us know that this student connected with you.

Name of person responding: _____

Today's Date: _____

_____ The above named student/family contacted us on _____ and was provided appropriate services.

____ We have no record of this student/family making contact with us.

Please return this form to:

Mrs. Benson
Smith High School
1340 S. Highland Ave.
Johnston, Missouri 90005

Record of Contact with Referrer

Date: _____

To:

From:

Thank you for your request for assistance for _____.
(name)

A contact was made on _____.

Comments:

Appendix C

Tools to *Assist Clients with Referrals*

Two aids are presented here:

1. *Referral Decisions -- Summary Form*

2. *Guidelines and Follow-up Forms to Aid Referral Follow-through*

Referral Decisions -- Summary Form

Student's Name or ID # _____ Birthdate _____
Date of Request _____

Interviewed by_____ Date_____

Referred to:

1. On-campus program/resource: _____
2. Off-campus district resource (e.g., Counseling Center): _____
3. Off-campus community agency _____
4. No referral _____(please indicate why)

PLANS FOR ENROLLMENT

Person to contact_____ Phone_____
Location_____

Appointment time_____

Plans for making initial contact (anticipate any problems):

Back up plans:

If the above plan doesn't work out or if you need additional information or help, contact _____ at_____

In a week or two, you will be contacted to see if everything worked out as planned.

GUIDELINES FOR ACKNOWLEDGING STATUS OF REFERRAL

Rationale:

The referrer and the person to whom an individual is referred both have an ethical responsibility to take steps to ensure the referred individual has been able to make an appropriate contact for needed services.

Thus, the referrer follows-up, if feasible, with the individual or, if necessary, with the person to whom the referral was made.

Similarly, the professional receiving a referral should take steps to inform the referrer whether or not the referred individual has been provided with the recommended services.

Procedures for Communicating Referral Status and Preserving Confidentiality:

Given the intent is to clarify referral status while preserving confidentiality about matters the client does not want others to know, the process of communication is designed to be simple and direct. For instance, in responding to an inquiry from the referrer, one of the following five responses should suffice.

1. The individual that you indicate having referred has contacted me, and I am providing the services for which you referred her/him. Thanks.

2. I had an exploratory session with the individual and referred her/him to _____. I will be following-up to see if the referral worked out.

3. The individual that you indicate having referred to me has not contacted me.

4. I have tried to make contact with the individual you referred but s/he has not responded to my messages.

5. I had an exploratory session with the individual, but s/he chose not to pursue the services I offer and was not interested in another referral. You may want to recontact her/him.

To facilitate such communication, a form such as the one attached may be useful.

Information Beyond Acknowledging Referral Status:

Except where legal reporting requirements prevail, communications about the nature of the individual's problems and matters discussed require client consent. When communication about such matters may serve the individual's best interests, it is important to convey the matter to the client and to seek a signed release.

School's Record of Response to Request for Assistance in Addressing Concerns about a Student/Family

Name of student _____

Name of staff member who made contact with student _____

Date of contact with student _____

The following are the results of the contact:

Follow-up needed? Yes ___ No ___

_____

If follow-up:

Carried out by _____ on _____
(name of staff member)

Results of follow-up:

Was permission given to share information with referrer? Yes ___ No ___

If yes, note the date when the information was shared _____

If no, note date that the referrer was informed that her/his request was attended to _____

Form Used to Aid Follow-Up on Referral Follow-Through

The following form should be used in conjunction with a general calendar system (a "tickler" system) that alerts staff to students who are due for some follow-up activity

Student's Name: _____ Today's Date: _____

DATES FOR FOLLOW-THROUGH MONITORING

Scheduled date for Immediate Follow up_____ (about 2 weeks after referral)

Scheduled date for Long-term *first* Follow up_____

Schedule for *Subsequent* Long-term Follow ups _____ _____ _____

I. Immediate Referral Follow up Information

Date of referral _____ Today's date_____
Immediate Follow up made by_____ Date_____
_____ Date_____
_____ Date_____

Service Need	Agency (name and address)	Phone	Contact person	Appt. time

A Put a check mark next to those agencies with which contact was made;
B Put a line through agencies that didn't work out;
C Put a circle next to agencies still to be contacted.

Indicate any new referrals recommended

Service Need	Agency (name and address)	Phone	Contact person	Appt. time

---

II. Long Term Referral Follow-Up Information

Have identified needs been met?

Contact the student at appropriate intervals (beginning three months after referral) and administer "Follow-up Interview Form -- Service Status."

Appendix D

Tools to Aid in *Assuring Quality of Care*

Two tools are provided here:

1. *Follow-up Rating Forms -- Service Status*

2. *Management of Care Review Form*

Follow-up Rating Form – Service Status **(Intervener Form)**
(To be filled out periodically by ***interveners)***

To (Intervener's name)

From: _____, Primary Care Manager

Re: Current Status of a client referred to you by _____ school.

Student's Name or ID # _____ Birthdate _____ Date_____

Number of sessions seen: Ind.___ Group ____

What problems were worked on?

Current status of problems worked on: (Severity at this time)

1	2	3	4
very severe	severe	not too severe	not at all severe

If the problems worked on differ from the "presenting" problems (e g., referral problem), also indicate the current status of the presenting problems.

1	2	3	4
very severe	severe	not too severe	not at all severe

Recommendations made for further action:

Are the recommendations being followed? YES NO
If no, why not?

How much did the intervention help the student in better understanding his/her problems?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

How much did the intervention help the student to deal with her/his problems in a better way?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

Prognosis

1	2	3	4
very positive	positive	negative	very negative

Follow-up Rating Form -- Service Status **(Client Form)**
(To be filled out periodically by the clients)

Student's Name or ID # _____ Birthdate _____ Date_____

1. How worthwhile do you feel it was for you to have worked with the counselor?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

2. How much did the counseling help you better understand your problems?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

3. How much did the counseling help you deal with your problems in a better way?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

4. At this time, how serious are the problems for you?

1	2	3	4
very severe	severe	not too severe	not at all severe

5. How hopeful are you about solving your problems?

1	2	3	4
very hopeful	somewhat hopeful	not too hopeful	not at all hopeful

If not hopeful, why not?

6. If you need help in the future, how likely are you to contact the counselor?

1	2	3	4
not at all	not too likely	likely to	definitely will

Management of Care Review Form

Student's Name or ID # _____ Birthdate _____

Primary Manager of Care _____

Management of Care Team (including student/family members):

_____ _____ _____

_____ _____ _____

_____

Initial Plan Date management of care file opened: _____

Student Lives with: _____ Relationship _____
Address_____ Phone _____

Home language _____

Type of concern initially presented
(briefly describe for each applicable area)

	How serious are the problems? not too serious					**very serious**
Learning:	1	2	3	4	5	6
Behavior:	1	2	3	4	5	6
Emotional:	1	2	3	4	5	6
Other:	1	2	3	4	5	6

Problem Identified and Referred by: _____ date_____

Initial client consultation done with: _____ date _____
Conducted by:_____

Indicate diagnosis (if any): _____

Recommendations/Decisions/consents:

Planned Date for Immediate Follow-up: _____
(2 weeks after recommended action)

Immediate Follow-up Date: _____

Appropriate client follow-through? Yes No

If no, why not?

Is the original plan still appropriate? Yes No

If no, why not?

What changes are needed?

Any problems with coordination of interventions? Yes No

If yes:

What needs to be done? By Who? When? Monitoring Date:

If plan has changed, indicate new recommendations/decisions (including plans for improving coordination):

SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

Planned date for first team review: _____
(in about 2 months or sooner if necessary)

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.

First Team Review Date: _____

Team members present:

_____ _____ _____

_____ _____ _____

General Update on Client Status (indicate source of information, progress, ongoing concerns, etc.)

With respect to concerns initially presented, at this time --

	Amount of Improvement Seen not too much					very much
Learning:	1	2	3	4	5	6
Behavior:	1	2	3	4	5	6
Emotional:	1	2	3	4	5	6
Other:	1	2	3	4	5	6

Appropriate client follow-through? Yes No

If no, why not?

Is the current plan still appropriate? Yes No

If no, why not?

What changes are needed?

Any problems with coordination of interventions? Yes No

If yes:

What needs to be done? By Who? When? Monitoring Date:

If plan has changed, indicate new recommendations/decisions (including plans for improving coordination):

SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

Planned date for next team review: _____
(in about 2 months or sooner if necessary)

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.

Note: This sheet may be used several times over the course of intervention (e.g., every 2 mths)

Ongoing Team Review Date: _____

Team members present:

_____ _____ _____

_____ _____ _____

General Update on Client Status (indicate source of information, progress, ongoing concerns, etc.)

With respect to concerns initially presented, at this time --

	How Severe? not too severe					very severe
Learning:	1	2	3	4	5	6
Behavior:	1	2	3	4	5	6
Emotional:	1	2	3	4	5	6
Other:	1	2	3	4	5	6

Appropriate client follow-through? Yes No

If no, why not?

Is the current plan still appropriate? Yes No

If no, why not?

What changes are needed?

Any problems with coordination of interventions? Yes No

If yes:

What needs to be done? By Who? When? Monitoring Date:

If plan has changed, indicate new recommendations/decisions (including plans for improving coordination):

SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

Planned date for next team review: _____
(in about 2 months or sooner if necessary)

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.

End of Intervention Date _____

Final Update on Client Status (indicate source of information, progress, ongoing concerns, etc)

With respect to concerns initially presented, at this time --

	How Severe? not too severe					very severe
Learning	1	2	3	4	5	6
Behavior	1	2	3	4	5	6
Emotional	1	2	3	4	5	6
Other	1	2	3	4	5	6

Why is the intervention ending?

If the client **still needs assistance**, what are the ongoing needs?

What plans are there for meeting these needs?

If there are no plans, why not?

SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

With intervention ending, the primary manager must be certain that (1) everyone who should be informed is provided relevant information and (2) evaluation data are entered into the appropriate systems.

We hope you found this to be a useful resource. There's more where this came from!

This packet has been specially prepared by our Clearinghouse. Other Introductory Packets and materials are available. Resources in the Clearinghouse are organized around the following categories.

CLEARINGHOUSE CATEGORIES

Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - Collaborative Teams
  - School-community service linkages
  - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Other System Topics: _____
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - Systemic change strategies
  - Involving stakeholders in decisions
  - Staffing patterns
  - Financing
  - Evaluation, Quality Assurance
  - Legal Issues
- Professional standards

Programs and Process Concerns:

- Clustering activities into a cohesive, programmatic approach
  - Support for transitions
  - Mental health education to enhance healthy development & prevent problems
  - Parent/home involvement
  - Enhancing classrooms to reduce referrals (including prereferral interventions)
  - Use of volunteers/trainees
  - Outreach to community
  - Crisis response
  - Crisis and violence prevention (including safe schools)
- Staff capacity building & support
  - Cultural competence
  - Minimizing burnout
- Interventions for student and family assistance
  - Screening/Assessment
  - Enhancing triage & ref. processes
  - Least Intervention Needed
  - Short-term student counseling
  - Family counseling and support
  - Case monitoring/management
  - Confidentiality
  - Record keeping and reporting
  - School-based Clinics
- Other program and process concerns: _____

Psychosocial Problems

- Drug/alcoh. abuse
- Depression/suicide
- Grief
- Dropout prevention
- Learning Problems
- School Adjustment (including newcomer acculturation)
- Pregnancy prevention/support
- Eating problems (anorexia, bulim.)
- Physical/Sexual Abuse
- Neglect
- Gangs
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Gender and sexuality
- Reactions to chronic illness

- Other Psychosocial problems: _____

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